The following document is intended to be a general overview of the process of developing a risk management program in a health center. The information contained herein is not intended to constitute legal advice on specific factual issues, nor is it intended that readers will rely on this document to resolve their own legal matters. Due to the many complex legal issues involved in risk management, as well as the differences in laws from state to state, it is recommended that each health center consult with its attorney in designing and setting up a risk management program.

I. Purposes for a Risk Management Program

Reduce the risk of injury or unacceptable medical outcome.

Reduce the risk of injury to health center staff.

Avoid corporate liability by the health center.

Avoid personal liability of directors, officers, providers and staff of the health center.

Reduce the risk of loss of the health center's property.

Reduce the risk of loss of health center financial assets.

II. Developing A Risk Management Program

1. Responsibility

    1. The Governing Board is the entity within each health center which possesses the ultimate responsibility for establishing the health center's policies.

    2. Since the governing board cannot (and should not) be involved in the day-to-day administration of the adopted policies, this function must be delegated to a staff member. That person must be responsible for assuring that the board's policies are carried out in a timely and professional manner.

B. Structure of the Program

    1. The Governing Board should consider either forming a risk management committee or assigning risk management responsibility to on existing committee (e.g., the quality improvement committee).

    2. The board should create specific focus areas for analysts of risk management concerns. This list should then be prioritized based upon the likelihood of serious problems in the area as well as the human and economic consequences of the risks. Examples:

        a. facility
        b. equipment (including level of. technology)
        c. credential, license and reference checking
        d. quality improvement

e. informed consent procedures
f. security
g. financial integrity
h. funding source relations

3. The board should either develop or assign to the Risk Manager.

4. Each of the identified risks should be classified according to a format which will permit cost effective management of the risk.

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5. Following the identification of specific risks, an action plan should be developed to reduce, eliminate or minimize the occurrence of the risk.

C. Costs of a Risk Management Program

, Costs-which must be considered include:

1. Costs of the occurrence of a risk, including:

a. liability payments;
b. increased insurance payments;
c. damage to reputation affecting patient load and revenue;
d. cost of repairing or replacing defective equipment; and
e. cost associated with loss of employees.

2. Costs associated with efforts to prevent or manage risks, including:

a. employee costs associated with implementing strategies;
b. insurance costs;
c. purchase or updating of equipment, facilities and supplies; and
d. reduction in physician productivity associated with increased non-patient care activities.

III. Classification of Levels of Risks

A. Risks which **must** be prevented

1. Definition:

a. Risks whose costs of occurrence are higher than their cost of management and whose occurrence may invoke legal sanctions in addition to liability for negligence (includes intentional torts and injuries caused by gross negligence).

2. Examples:

   a. performing an invasive procedure on the wrong patient
   b. operating on the wrong limb
   c. foreign body left inside patient
   d. intentional harmful acts directed toward a patient by health center staff
   e. known unsafe facility conditions

3. Implication of the classification:

   a. Generally, liability for risks occurring in this category may be proved in court without resorting to an expert witness to prove the standard of care which should have been followed (i.e., even a lay person would know that the action was wrong).

B. Risks which **should** be prevented

1. Definition:

   a. Risks whose cost of occurrence is greater than the cost of management but whose occurrence will be considered only as negligent (e.g., negligent injuries).

2. Examples:

   a. infection based on lack of appropriate sterilization
   b. failure to perform indicated diagnostic testing
   c. inappropriate treatment based upon diagnostic information available
   d. inadequate after-hours security

3. Implication of the classification:

   a. Injuries resulting from risks falling under this category will typically be measured against the appropriate standard of care as established by an expert witness.

C. Risks which **may** be prevented

1. Definition:

   a. Risks whose cost of occurrence is only slightly greater than the cost of management.

2. Examples:

a. Risk of illness or injury to health center employees based upon the performance of required Job responsibilities (e.g., exposure to illnesses of patients).

b. Risk of inadequate benefit and salary package to retain providers

3. Implications of the classification:

a. While there are many activities which centers may take in reducing risks to employees, it may not be economically feasible to remove all risks of this type.

D. Risks which **often are not** prevented

1. Definition:

a. Risks whose cost of occurrence is less than their cost of management.

2. Examples:

a. implications of decisions of non-physician personnel in patient care;
b. decisions regarding provision of abortion services even though term pregnancy may be a greater risk to particular patients;

c. purchase of levels of insurance coverage which would guarantee no health center financial loss

3. Implications of the classification:

a. While the health center recognizes the risk and may take some steps to prevent its occurrence, economic reality dictates that complete elimination of the risk would be impossible.

E. Risks which are **not** preventable

1. Definition:

a. Risks whose occurrence is unmanageable.

2. Examples:

a. acts of God (earthquake, flood, fire, tornado, etc.)
b. acts of war
c. other forces beyond the health center's control

3. Implications of the classification:

a. Since the health center cannot control the occurrence of o risk in this category, it must next evaluate whether insurance is available to cover the risk and whether the price of the insurance coverage is justified based upon the likelihood of the occurrence of the risk.

IV. Types of Potential Health Center Losses

, In evaluating a particular risk management strategy or plan, the health center should consider both direct loss and indirect loss.

A. Direct Losses

1. Damage or loss of real property, such as land, parking lots, clinic and other facilities and fixtures which are permanently affixed to land or buildings.

2. Loss or damage to personal property such as medical equipment, furniture, computers, etc.

3. Loss of cash, either physically located in the health center's offices or on accounts which the health center has established.

4. While patient records may also be considered personal property, these records should receive special consideration (and protection) insofar as they contain valuable information relating to diagnoses and treatment.

5. In addition to cash on hand, the center must protect current and future earnings from liability losses in such areas as:

a. malpractice;
b. public liability;
c. director's and officer's liability;
d. worker's compensation
e. automobile liability.

B. Indirect Losses

1. The loss of future patients (visits) would result in lack of revenues which those visits may produce.

2. The loss of patient and other public goodwill will have an effect on many aspects of the organization, including: positive marketing, fund raising efforts and efforts to acquire and retain good employees.

3. The center must guard against the loss of the knowledge, expertise and training of all levels of employees.

V. Common Health Center Risks and Strategies for Risk Management

A. **Risk**

, Injury to patients and potential for resulting malpractice liability

Strategy

1. Hire well-qualified professionals for all patient care positions within the center.

   a. Develop a board-approved professional standards criteria for each patient care position covering such items as education, accredited medical school, residency training, licensure, board eligibility or certification, years of experience, etc.

   b. Develop a procedure to verify each of the requirements set out in the professional standards criteria.

   c. Permit input into the hiring decision by the Medical Director, staff physicians, and other professionals with whom the new provider will be working closely.

2. Development of a quality improvement system composed of at least the following elements:

   a. Establish a board and professional staff committee which meets regularly in accordance with a work plan developed prospectively for a six to twelve month time period.

b. Develop quality improvement policies and procedures which prescribe the standards which the health center sets for its medical services.

c. Establish a system of professional performance evaluations of each provider. It is recommended that this activity be conducted by professionals within the provider's own field (e.g., Medical Director, Dental Director, Nursing Director, etc.).

d. Establish clinical protocols for a number of the *most commonly performed procedures and/or treatment regimens for the most common diagnoses.*

e. Perform periodic procedure audits (anonymously by other providers) to assure adherence to the established protocols and for completeness of documentation within the patient's medical record.

f. Establishment of periodic special purpose audits (e.g., a study focused on a recurring health problem within the community, or outcome audit to verify the appropriateness of current protocols, a medication usage study, etc.).

g. Conduct at least an annual patient satisfaction survey which measures the patient's level of satisfaction with the providers, support staff, and services performed.

h. Develop appropriate patient education materials and programs in order to assist patients to participate in their own healthy lifestyle decisions.

i. Develop procedure manuals in order to establish appropriate quality controls and monitoring systems for the ancillary services offered by the health center (i.e. lab, x-ray, and pharmacy).

3. The health center should provide a format for providers to continue their education in furtherance of enhancing skills in areas relevant to the health center's patients.

4. At a minimum the center should develop and implement tracking in the following areas:

a. Lab and x-ray services (either internal or external) for which diagnostic results and interpretation are unavailable during the patient's visit.

b. Referrals to other area providers either for inpatient or outpatient services.

c. Subspeciality consultation.

d. Immunization schedules.

e. Tracking systems for scheduled visits for obstetric patients who will be followed during maternity by the center's physicians.

f. Follow-up for patients with specified chronic conditions who will require ongoing monitoring and evaluation.

5. Development of a health care plan which contains realistic, achievable, quantified goals.

6. In order to provide support personnel with the information necessary to assist and support the provider's activities, it is important for the health center to develop a telephone, appointment and triage policy manual. This manual will provide guidance on:

a. Methods to insure that patients make appointments as needed.

b. Methods to minimize no-shows.

c. Methods for appointment scheduling.

d. Protocols on how to triage patients (best done by age groups).

e. Priorities for scheduling of patients, including facts to ascertain and handling of emergencies.

A. **Risk**

, Compliance with the informed consent process

Strategy

1. Before the center may put in place appropriate policies concerning informed consent, it is essential to understand the doctrine. Generally, a patient has the right to prevent unauthorized medical treatment. Protection of this right rests in the obtaining of informed consent from the patient. **Failure to obtain informed consent prior to medical treatment may give rise to a cause of action for either battery or negligence.** Generally, battery actions may occur in the following situations:

a. the physicians fails to obtain any consent to treatment,
b. the physician exceeds the scope of the consent given,
c. the physician misrepresents the severity of the operation, or
d. the physician performs an operation significantly different from the one consented to.

Other actions involving lack of informed consent are generally brought on a theory of negligence or failure to perform a duty (obtaining of informed consent) that the physician was bound to do.

2. While the theory for recovery in an action for lack of informed consent is different from the theory in an action for medical malpractice, the two issues are often combined in actions brought by a patient who is unhappy with the results of medical care. That is, even if the patient is unable to prove that the physician was negligent in either diagnosing or treating the complaint, the patient may raise the issue of lack of informed consent. The patient may claim that had the potential adverse consequences of the procedure been adequately explained by the physician, then the patient would not have agreed to the procedure. Thus the emphasis shifts from how well the physician performed the procedure to how well the physician explained the potential risks of the procedure to the patient.

In many cases, it may be easier to prove lack of informed consent than to prove malpractice.

3. Consent for routine (non-invasive) care

   a. The law in many states provides that a patient who makes an appointment and presents himself at the clinic for medical care implied consent to routine (non-invasive) diagnosis and treatment. However, the center may wish to have the patient sign a consent form authorizing routine (non-invasive) services typically provided in an office setting. This form could be combined as part of the registration process and/or combined with the patient's statement of financial responsibility for charges incurred at the clinic.

4. For invasive procedures and those non-invasive procedures for which there is either a risk of significant negative outcome from the procedure or a high risk of any negative outcome, the physician should follow an established process for obtaining the patient's informed consent before performing the procedure.

a. The process of obtaining informed consent should consist of:

   i. educating the patient about diagnostic, therapeutic, or research procedures so that the patient can arrive at an informed decision;

   ii. actually obtaining the patient's permission to proceed;

   iii. documenting the above exchange and consent in the form of a written document (the consent form).

b. The specific steps involved in informing the patient about the procedure should consist of the following:

   i. explanation of procedures to be done, their purposes and the identification of any experimental procedures;

   ii. description of any risks, discomforts, side effects, or potential reactions associated with the procedure;

   iii. description of the reasonably expected benefits;

   iv. disclosure of alternatives that may be advantageous;

   v. offer to answer any questions which the patient may have;

   vi. actual obtaining of the patient's informed consent and signature on appropriately drafted consent form;

   vii. instruction that the patient is free to withdraw consent at any time without prejudice;

   viii. in the event that a patient withholds consent to a procedure, the physician should explain the risks attendant to choosing not to proceed with the operation.

The center should keep in mind that informed consent is a process and not a form. It is the exchange of information between a physician and patient that culminates in the latter agreeing to undergo an operative procedure, conducted by the provider, that marks the end of the consent process. Documentation of consent is merely a written historical account of what transpired between the parties. It is never the actual consent.

5. The center should to consider its policy on permitting minors to consent for their own treatment at the health center, either with or without their parent's consent or knowledge. This policy should address such areas as:

   a. age of majority, which is now eighteen years old in most states.

   b. age of reason--an arbitrary age typically between 12-18 years old, when a child has not attained the age of majority, yet has attained sufficient judgement to be able to rationally and reasonably make his or her own health care decisions.

   c. laws defining emancipated minors in the state (i.e., minors who have married, delivered a child, live independently outside their parent or guardian's home, etc.).

   d. Federal rules and some state laws provide for some specific instances in which minors may consent to their own treatment. Examples of these situations include treatment for alcohol and drug abuse, treatment for venereal disease, etc.

6. Many of the same considerations applying to minors giving consent for their own services will also apply to incompetent persons, whether or not they have been adjudged incompetent. Issues regarding the definition of competence and who may give consent to treatment for an incompetent person must be resolved in relation to obtaining informed consent.

7. In addition to any consent forms which the center develops for its own use, it is important that the provider not neglect to document the steps in the informed consent process in the patient's medical record.

8. It Is recommended that the health center develop a consent policy and procedure manual. The consent manual should:

   a. establish appropriate consent practices,

   b. educate staff about proper consent practices,

   c. facilitate communication of pertinent information between patient and health professional and among health professionals,

   d. assure proper documentation of consent,

   e. anticipate consent "problem" situations, and

f. the manual should include sections which cover at least the following issues:

i. voluntary of consent;

ii. mental capacity to consent:

iii. legal capacity to consent:

iv. disclosure of material risk information;

v. disclosure of information regarding benefits that might be anticipated from the procedure;

vi. disclosure of the nature and severity of risks and discomforts associated with the procedure;

vii. disclosure of alternative forms of treatment, including both surgical and non-surgical interventions;

viii. the risks associated with foregoing all treatment;

ix. responses to patients' questions;

x. staff responsibility for disclosing pertinent information to the patient and who is to obtain the authorization for surgery (should always be the person performing the procedure);

xi. the requirements for consent set forth in state statutory and case law;

xii. responsibility for education of staff regarding consent requirements; and

xiii. management of anticipated "problem" situations such as:

< medicolegal emergencies;

< situations in which consent is impractical, but the patient does not present with a true medicolegal emergency;

< incompetent patients who are without guardians or other legal representatives;

- separated or divorced parents who have joint custody of their child and who cannot agree on appropriate surgical treatment;
- adults who refuse certain forms of treatment based on religious beliefs;
- patients who refuse surgical care and who exhibit alcohol or drug intoxication; and
- acceptability of surgical consents from minors.

C. Risk

, Losses related to the facility and its contents

Strategy

1. The health center should anticipate potential loss due to illegal entry into the clinic facility and prevent breaking and entry through the following steps:

   a. In analyzing the protection afforded by a door lock, make sure you've got a sturdy door. Hollow core doors ore easy to penetrate. Replace them with solid wood or with metal doors. Frames should be made of equally strong materials.

   b. If the outside door swings out, the hinges will be on the outside. It's easy to remove the hinge pins and the door. Have the hinge pins secured.

   c. Experts say the pin cylinder lock is the toughest to pick. They recommend a dead bolt, a thick steel shaft that extends from lock into door frame, which can't be slipped open with a thin piece of plastic.

   d. Make sure the door is properly installed. If the gap between door and frame is wide, a crowbar can create entry opportunities.

   e. If doors have glass panels, the sturdiest dead bolt lock can be opened by an interloper who breaks the pane and reaches in.

f. For rear and basement doors, consider the police lock. It's a metal bar that's rigidly bracketed at an angle against the inside of your door. (check local fire ordinances first.)

g. Windows that are accessible, particularly on ground floors, need special attention. Use locks on all windows and keep them locked.

h. Alarms are very useful but costly. Make your decision for or against their use based on the prevalence of crime in your area and the replacement cost of your valuables.

i. Be sure to use decals on windows and doors, warning criminals that the premises are protected with on alarm system.

j. In some communities the police or sheriff's office will survey business premises free of charge and give security tips on everything from locks to alarm systems.

k. Mark all your valuables permanently with some kind of identification.

2. Protect business property through the use of measures such as the following:

a. Lock computers to desks with security devices. Record the serial numbers of your office equipment. Engrave your equipment with your identification codes.

b. Label keys, using a code to indicate which doors they're used for. Have your key marker engrave "Do Not Duplicate" on all keys. Keep a record of who has what keys and make sure they are returned when employees no longer need them.

c. Skylights and ventilation ducts are tempting to burglars because they're usually invisible from the street.

d. Don't keep petty cash in a desk drawer. Put your cash register up front so it's visible from the street. Empty your cash drawers and leave them open--visibly so--so a burglar can see they are empty.

e. If your clinic is in a rural or suburban area, fence in the property.

f. Make sure you hove adequate lighting.

3. Adopt miscellaneous policies such as the following:

   a. Purchase a fire resistant safe or deposit box to safeguard all valuables which are routinely left in the center overnight.

   b. Develop a schedule for backup and removal from the premises of computer files to permit reassembly of the health center's records in the event of a computer "crash"or other mishap.

   c. Consider microfilming and/or removing all inactive medical records. Often, these records are stored in a basement which may be subject to flood, fire or similar problems.

   d. Install smoke detectors and sprinkler systems as required by local/state fire safety code. Have working fire extinguisher placed in locations accessible to employees.

   e. Securely lock all patient record file drawers each night, as well as locking the door to the room in which they are maintained.

   f. Develop a "no smoking" policy within the health center.

D. Risk

, Automobile security and liability protection

Strategy

1. If the health center owns and operates a vehicle for any part of the clinic, the following tips for loss prevention may be helpful.

   a. Employees should close all windows, lock all doors and take the keys.

   b. Park in a well-lighted, and preferably well-travelled, area.

   c. Park with front wheels turned sharply, making it difficult for the professional thief to tow your car away.

   d. Consider installing a theft deterrent device if does not already have one.

e. If the vehicle has been stolen and found, you'll be able to speed its return if you can prove it's yours, even if the vehicle ID number has been removed. Etch the vehicle identification number in several hard to find spots on your car. Write your ID in yellow crayon in hidden places under the hood or trunk.

2. The health center should consider the following steps to reduce the risk of public liability related to the use of a vehicle.

   a. The car should be maintained in good repair.

   b. The center should make a copy of each employee's driver's license if the employee will be driving on corporation business.

   c. Prior to the start date of any employee who will be driving for the center, management should receive a copy of the individual's driving record from the State Vehicle Commission.

   d. If employees will be using private vehicles for corporate business, the center should check with its insurance representative to be sure that the corporation's vehicle liability policy will cover private vehicles used for corporate business purposes.

E. Risk

, General (Public) Liability

Strategy

1. If the clinic schedules evening hours, it is important that sufficient number of staff be present on-site to protect the patients and the employees.

2. If the health center is located in a "high crime" area, it should consider employing a security guard either full time or during evening hours.

3. Any unusual events (whether accompanied by any discernible theft or other illegal activity) should be reported to the local authorities for investigation.

4. Clinics where elderly patients will be seen should-have rails along the walls, corridors wide enough to allow wheelchairs to be moved in and out easily, and rest rooms with handicapped accommodations. Carpeting should be thick and well padded in case of falls and there should not be large areas that are uncarpeted or that provide a hard surface.

5. In offices providing mental health services, there should not be items that can be thrown or which may harm the patient or employees.

6. Office equipment should be in protected alcoves where possible, and the layout should provide room for this. Where this is not possible, equipment should be placed behind semi-protective barriers that ore smooth and ovoid dangerous sharp corners.

In addition, equipment should be tested according to manufacturer's instructions and serviced according to maintenance instructions to avoid electrical shocks or improper functioning that could cause injury to a patient or a staff member.

7. Maintenance personnel should be evaluated carefully when they ore hired and their methods of handling the equipment and the office furnishings should be monitored periodically.

8. In areas where snow is a factor, snow removal is a vital safety aspect, as is maintenance of the surfaces of the driveways and hallways.

9. Waiting area safety is a vital concern. It is important that staff persons in the office be able to see the waiting room in order to identify any such problems promptly, or monitor the area frequently.

F. **Risk**

, Issues related to medical records

Strategy

1. Record design should promote maximum utility and function as well as protection of the medical record contents including review of such items as:

   a. folder design which protects and organizes record contents and allows rapid identification of the patient record for retrieval and filing;

   b. dimensions of the file folder which is sufficient to handle standard (letter size) documents;

   c. suitable file paper stock to provide durability in anticipated use;

   d. a fastener system which promotes organization and maintenance of medical record contents; and

e. folder identification and filing systems which are appropriate for the record volume and level of activity in the health center, addressing such topics as file identification method, filing method, color coding method, etc.

2. Examples of the basic forms which should be retained in the medical record include:

a. patient registration/identification
b. patient history
c. patient physical examination
d. problem list
e. progress notes
f. laboratory reporting
g. consent forms

Other common forms include:

a. family planning forms
b. prenatal forms
c. nutrition assessment forms
d. dental forms
e. social assessment forms

3. Four main sections in an integrated medical record include:

a. the data base,
b. documentation of ongoing care,
c. administrative forms, and
d. sections for program specific forms that cannot be integrated.

4. The health center should consider the use of a problem-oriented medical record which systematically identifies health problems and attempts to resolve them through four interrelated processes:

a. acquisition of a data base of relevant patient information;
b. identification of problems discovered during data base acquisition;
c. development of a plan to address identified problems; and
d. recording progress mode in resolving problems.

5. It is important that the center's medical record system os o whole have a high degree of credibility and integrity in the event that the records are scrutinized in the course of o malpractice action. The following items should be considered in reference to reducing the risk of problems associated with the medical record:

    a. Entries should be written legibly and in ink (not pencil).

    b. If more than one person may be making entries in the medical record, the entry should be signed or initialed.

    c. Entries in error should not be blocked out or mode illegible, but drawn through with a single line with a note above the entry stating that the entry was in error and where the correction may be found.

    d. Entries should be uniformly spaced on forms without any unusual or irregular blank spaces.

    e. No blank spaces should be left in answers to health questions.

    f. All cancellations, late arrivals and changes in appointments should be recorded.

    g. The patient should be informed of adverse occurrences in the course of treatment and a note should be placed in the record that the patient was informed.

    h. All requests for consultation (and responses) should be recorded.

    i. Records should never be tampered with once there is any indication that legal action is contemplated by the patient.

6. Records should be retained for at least the period of the statute of limitations for actions on contracts in your state. In the case of minors, records should be maintained until the minor is 24 years old.

7. The absolute confidentiality of records (as well as medical information which staff members may be in possession of) cannot be over stressed. The health center should discuss with its attorney the legal implications of release of records to the following groups and develop policies related to the same:

a. patient
b. family members
c. parents
d. minors
e. incompetent persons
f. guardians
g. attorneys
h. third-party payers
i. other health professionals
j. other third parties

8. The health center should clearly specify in policies and in its physician contracts that medical records are the property of the health center. Health center records may only be copied for another physician (including health center physicians who may go into private practice) upon the written release of the patient.

G. Risk

, Director and officer's liability

Strategy

1. Board members must understand their primary duties as a board member of loyalty and due care. The duty of loyalty involves a board member pledging his or her loyalty to the health center and acknowledging that his or her personal interests cannot be furthered at the expense of the health center.

2. Board members should strive to comply with the following suggestions in order to avoid the possibility of personal liability:

   a. Ensure that board minutes are:

      i. Complete and accurate
      ii. Document all board decisions and actions
      iii. Include what was done, when, why and who was involved
      iv. Document any dissenting notes to actions token

   b. Read and understand bylaws, board policies and procedures as they apply to officer and director responsibility.

   c. Investigate the legal implications of board decisions prior to making the decision.

   d. Ensure that the purposes, reporting relationships and authority of all board committees are clear and uniformly followed.

e. Prepare for, attend, and participate in every board meeting possible.

f. Conduct board meetings in an unbiased manner, in accordance with meeting rules such as Robert's Rules of Order. Encourage open discussion and record dissenting votes in the minutes.

g. Never make "rubber stamp" decisions based upon incomplete information.

h. Develop, adopt and enforce a board conflict-of-interest policy.

i. Ensure that the information flow to the board is adequate and improve this where necessary.

3. Board members should be aware of and take steps to guard against the following "high risk" areas for director liability:

a. Failure to meet standards established in corporate bylaws.

b. Negligence in monitoring, hiring and credentialing professional staff.

c. Issues involved in developing and administering personnel policies.

d. Allowing any incompetent professionals to continue to be employed at the health center.

e. Failure to establish job responsibilities for and periodically review the performance of the Executive Director.

f. Failure to establish an adequate quality improvement program.

g. Covering up any patient injury or malpractice.

h. Allowing unsafe equipment or facility conditions to present danger to the public.

i. Participating in or permitting conflict-of-interest situations to continue.

H. **Risk**

, Loss of resources due to employee malfeasance

Strategy

1. Quality personnel: the best way to prevent embezzlement problems is to hire good personnel.

2. Divide book keeping duties: split up the accounting process as much as possible.

3. Use pre-numbered documents: by using pre-numbered receipts, charge slips, checks and deposit slips, it is easier to discover when they are missing and if they have been used to conceal embezzled funds.

4. Endorse all checks immediately: have an endorsement stamp made up that says "For Deposit Only" and that specifies your business account and account number.

5. Keep duplicate deposit slips: match duplicates against total cash receipts posted for each day to check for discrepancies.

6. Approve all adjustments, discounts and write-offs: no adjustment, discount or write-off should be permitted if it does not comply with the adopted sliding fee scale.

7. Make sure the sum total of patient accounts equals the control total of accounts receivable.

8. Send detailed charge and payment statements to patients.

9. Insist employees take vacations: some devoted employees never take vacations because they are afraid to leave their duties to someone else.

10. Invoice and statement control: have the financial deportment present the invoice and statements with the check when you pay for supplies or services.

11. Keep financial records in the office.

12. Periodically add up journal sheets: Supervisors should periodically add up the figures of the bookkeeper. This will let the bookkeeper know you are watching things and would detect any massive errors or cheating.

13. Periodically check an entire day's records for accuracy.

14. Have the completed day sheet reviewed: even If a supervisor doesn't have time to review the sheets each day, the routine delivery of day sheets to the desk each day gives the impression that the sheets are being reviewed.

15. Be alert: Watch for warning signals from your employees, such as:

    a. Casual office procedures or sloppy book keeping.

    b. Resisting change.

    c. The appearance of living beyond means or a noticeable change in spending habits.

    d. IOUs in the petty cash.

    e. Switching vendors for no apparent reason.

    f. High pressure collection tactics that yield no visible results.

    g. Staff involved with financial matters who don't allow others to help in the bookkeeping or running of the accounts receivable tape at the end of the month.

    h. Missing petty cash slips and cash receipts.

    i. Resentment expressed toward physician or management lifestyle or income.

I. Risk

, Injury to or loss of employees

Strategy

1. Job description: Each employee should have on accurate, current and complete job description which clearly sets out the organization's expectation with regard to the employee's performance. The Job description should contain at least the following components:

a. Accurate position title
b. Position purpose
c. Reporting relationship
d. Specific job responsibilities
e. Time line for job responsibilities (if applicable)
f. Supervisory responsibilities (if applicable)
g. Minimum requirements for the position, including:

    i. Education
    ii. Experience
    iii. Knowledge, licensure or certification, skills and abilities
    iv. Special requirements (e.g., bilingual, ability to operate equipment)

2. Orientation and training: Thorough initial orientation and training programs are essential in ensuring employee safety and acceptable job performance.

3. Periodic in-service: When areas of particular interest are able to be addressed by local experts (either in-house or in the community).

4. Proper supervision: In order to monitor safety programs which have been initiated by the health center, management should initiate periodic observation techniques.

5. Grievance procedures: The availability and adherence to objective, functional grievance procedures can serve to defuse employee dissatisfaction as well as to provide information on job-related risks.

6. Procedure manuals: The health center should develop and make available to all affected employees, procedure manuals for properly performing necessary health center functions.

7. Minimize risk: The health center should focus on specific areas of high potential risk for employee injuries and ensure that all possible precautions are taken to protect employees' health. Examples of risks which should be analyzed include:

    a. X-ray equipment which should be operated and maintained according to manufacturer's guidelines.

b. Laboratory services which should be performed by properly trained professionals in accordance with procedures developed by the center's quality improvement committee.

c. Handling of toxic or potentially toxic waste and byproducts.

d. Preventing needle sticks and other potential exposure to AIDS and hepatitis.

8. Exit interviews: Upon the resignation of providers and other employees, management should conduct an exit interview to frankly and openly discuss work conditions, recruitment and retention issues, risk management issues and other relevant suggestions for improvement.